UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA

IN RE: DIGITEK®
PRODUCT LIABILITY LITIGATION

Master Docket No.

MDL No. 1968

PLAINTIFF: Judy A. Whitaker, as Executrix of THE ESTATE OF ANNA FIGHT
(name)

AMENDED DIGITEK® PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Fed. R. Civ. P. 33 and as responses to requests for production pursuant to Fed. R. Civ. P. 34 will be governed by the standards applicable to written discovery under Fed. R. Civ. P. 26 through 37. The questions and requests for production contained in the Fact Sheet are non-objectionable and shall be answered without objection.

In filling out this form, please use the following definition: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In addition, to the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary.

I. CASE INFORMATION

1. Please state the following for the civil action that you filed:

   a. Case caption: **Please see attached.**

   b. Civil Action Number: **3:09-CV-234**

   c. Court in which action was originally filed: **Jefferson Circuit Court. Removed to United States District Court Western District of Kentucky**

   d. Your attorney:

Name: **Lawrence L. Jones II**

Address: **Bahe Cook Cantley & Jones, Kentucky Home Life Building, 239 South Fifth Street, Suite 700, Louisville, KY 40202**

2. Name of person completing this form: [redacted] **with assistance of and transcription by counsel**

3. Please list any other names you have used or by which you have been known and dates you used those names:

[redacted]

4. Your current address: [redacted]

5. If you are completing this Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

a. Describe the capacity in which you are representing the individual or estate:
Executrix of the Estate of [redacted]

b. If you were appointed as a representative by a court, state the:

Court Which Appointed You: **Oldham District/Probate Court**

Date of Appointment: **5/31/2007**

c. What is your relationship to the individual you represent: [redacted] **is the** [redacted] **of** [redacted]

d. If you represent a decedent's estate, state:

Decedent's Date of Death: [redacted]

Address of Place Where Decedent Died: **Baptist Hospital Northeast, 1025 New Moody Ln, Lagrange, KY 40031**

e. If you are claiming the wrongful death of a family member, identify any and all family members, beneficiaries, heirs or next of kin of that person, including their relationship to Decedent:

[redacted]

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO PURCHASED, OR PURCHASED AND USED DIGITEK®. WHETHER YOU ARE COMPLETING THIS FACT SHEET FOR YOURSELF OR FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE DIGITEK® PURCHASER OR PURCHASER AND USER.

II. CLAIM INFORMATION

1. Name of Digitek® Purchaser/User: [redacted]

2. Have you used any other names in the last five (5) years? Yes ____ No X

   If yes, please list any such names that you have used:

   _____

3. Do you claim that you suffered bodily injuries as a result of taking Digitek®?

   Yes X No ___ If Yes, please answer the following:

   a. What bodily injuries do you claim resulted from your use of Digitek®?

      nausea, weight loss, weakness, fatigue, stroke and death

      _____

   b. When is the first time you saw a health care provider for any of the symptoms you link to your alleged injury? **2/28/2007**

   c. Are you currently experiencing symptoms related to your alleged injury?

      Yes ___ No X If Yes, please describe the symptoms: [redacted] **is deceased.**

      _____

   d. Did you see a doctor, clinic or healthcare provider for the bodily injuries or illness listed above?

      Yes X No ___ If Yes, who: **Medical Center Cardiologists for nausea, weakness, fatigue and weight loss. Baptist Hospital Northeast for her strokes.**

   e. Who diagnosed your injury? **Dr. Bruce Fisher and E.R. Doctors at Baptist Northeast.**

   f. Date of diagnosis: **2/28/07 Dr. Fisher. 4/23/07 and 5/11/07 E.R. Doctor at Baptist Northeast.**

   g. Were you hospitalized?

      Yes X No ___ If Yes, please answer the following:

1) Date of hospital admission: **4/23/07 and 5/11/07.**

2) Date of discharge: **5/1/07 discharged to nursing home. 5/11/07 -- death.**

3) Hospital name and address: **Baptist Hospital Northeast, 1025 New Moody Ln, Lagrange, KY 40031**

h. What harm or consequence including physical limitations, do you claim you suffered as a result of the bodily injury above, excluding any mental or emotional damages, lost wages or out of pocket expenses listed below?

[redacted] lost weight from her use of Digitek. She suffered nausea and weakness. After her first stroke, [redacted] lost the use of the left side of her body. After her second stroke, [redacted] lost her life. Additionally, during the period of her injury [redacted] lost significant quality of life.

i. Do you claim that your injury was caused by ingesting defective Digitek® medication?

Yes X No ___ If Yes, please answer the following:

1) Describe in detail what you claim the defect to have been in the Digitek® medication that you ingested: **Pills may have been double thickness or otherwise contained a larger dose than stated.**

2) How much of the defective product did you ingest? **Unknown to [redacted]**

3) When did you ingest the product? **Between 2/2007 and 5/13/2007**

j. Have you had any discussions with any doctor or other healthcare provider about whether Digitek® caused you to suffer any illness or injury?

Yes X No ___ If Yes, who: **Dr. Fisher stopped [redacted] Digitek as a result of anorexia, after [redacted] had nausea, weakness and weight loss. [redacted] did not discuss Digitek as a possible cause of her other injuries.**

4. Are you claiming mental and/or emotional damages as a result of taking Digitek®?

Yes X No ____

If Yes, what mental and/or emotional damages do you claim resulted from your use of Digitek®?

[redacted] quality of life was severely diminished after she had a stroke.

If **Yes**, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, state the following:

NAME	ADDRESS	CONDITION TREATED	DATES TREATED	MEDICATIONS PRESCRIBED

5. Are you making a claim for lost wages or lost earning capacity?

Yes___ **No** **X** If **Yes**, state the annual gross income you derived from your employment for each of the last five (5) years:

_____

_____

_____

6. Have you incurred any out-of-pocket expenses as a result of using Digitek®?

Yes___ **No** **X** If **Yes**, please identify and itemize all out-of-pocket expenses you have incurred: _____

_____

7. What other damages, if any, do you claim you suffered as a result of the purchase or ingestion of Digitek®?

The medication made [redacted] suffer nausea. She was unable to eat. She lost weight. She suffered two strokes. [redacted] suffered a significant loss to her quality of life. She did not have the energy to do the activities she liked to do. Ultimately, [redacted] died.

III. DIGITEK® PRESCRIPTION INFORMATION

1. Have you ever used Digitek®? **Yes** **X** **No** ____

2. If you answered **yes** to No. 1, identify the following for each period of time during which you took Digitek®:

DOSAGE (.125 MG OR .250 MG)	HOW OFTEN PER DAY OR WEEK?	DATE STARTED	DATE STOPPED	NAME OF PRESCRIBER
.125	3 per week	Approx. 2/2007	2/28/2007	Dr. Bruce Fisher
.250 Digoxin	daily	4/23/2007		

The above information was gathered from [redacted] medical records and Plaintiff's memory. [redacted] have taken some form of Digoxin in 2003. Medical records indicate [redacted] was given digoxin in the hospital and nursing home on 4/23/2007 and thereafter. Plaintiff has executed and attached the medical release. Defendant may obtain and review [redacted] medical records.

3. Name(s) and address(es) of pharmacies where prescriptions were filled: **Wal-Mart, 1015 New Moody Lane, La Grange, KY 40031. [redacted] may also have had prescriptions filled through Medco.**

4. Identify the condition for which you were prescribed Digitek®: **[redacted] is not aware of the specific condition for which [redacted] was prescribed Digitek.**

5. Did you receive any free samples of Digitek®?

Yes __ **No** X **If Yes, please state the following:**

a. Who provided the samples? _____

b. When were samples provided? _____

c. What was the dosage of the samples? _____

d. How many samples were provided? _____

6. Do you have in your possession or does your attorney have the packaging from the Digitek® you allegedly purchased, or purchased and used, and/or any Digitek® tablets?

Yes X **No**____

a. If yes, who currently has custody of the Digitek® packaging and/or tablets?

Lawrence L. Jones II

b. If you or your attorney is in possession of tablets, how many do you have? **2**

c. Have you or anyone on your behalf tested the Digitek® tablets in your possession?

Yes ____ **No** X **If Yes,**

1) Who tested the tablets? _____

2) What test(s) was performed? _____

3) How many tablets were tested? _____

4) When were the tests performed? _____

5) What were the test results?_____

_____

(NOTE: In lieu of answering the following Question Nos. 7a and 7b, please attach a clear copy of the product packaging and/or the label on the vial or blister pack of Digitek® in your or your attorney's possession that provides the information sought below.)
Please see attached photographs.

7a. Do you know the lot number(s) for any of the Digitek® you received?

Yes ____ No____

If **Yes**, what is/are the lot number(s): _____

7b. Do you know the expiration date for any of the Digitek® you received?

Yes ____ No____

If **Yes**, when is/was/were the expiration date(s): _____

8. Have you had any communication, oral or written, with any of the defendants or their representatives?

Yes ____ No_X__

If **Yes**, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and any defendants or their representatives:

_____

9. Have you ever used any other digoxin or digitalis product (i.e. Lanoxin)?

Yes____ No____

If **Yes**, please state: [redacted] **was given digoxin in the hospital and nursing home.** [redacted] **does not have personal knowledge of the brand given.**

DOSAGE (.125 MG OR .250 MG)	HOW OFTEN PER DAY OR WEEK?	DATE STARTED	DATE STOPPED	NAME OF PRESCRIBER

10. Are you aware that Digitek® was recalled? **A letter from Wal-Mart pharmacy was sent addressed to** [redacted] **May 8, 2008.**

Yes___ No ____ If **Yes**, please state the following:

a. When you became aware of the recall: **May 8, 2008**

b. How you became aware of the recall: **Wal-Mart Recall**

11. Did you discuss the recall with any healthcare provider or pharmacist?

Yes___ **No** **X** If **Yes**, please state the following:

a. When that discussion occurred:_____

b. With whom:_____

12. Did you return any Digitek® to Stericycle or any pharmacy?

Yes_____ **No** **X** If **Yes**, please state the following:

a. When did you return the product?_____

b. Do you have your paperwork regarding the return? **Yes**_____ **No**_____

c. To whom did you return the product?_____

13. Have you ever visited a website, chat-room, message board or other electronic forum containing information or discussion about Digitek®?

Yes___ **No** **X** If **Yes**, please provide the name of the website:_____

IV. MEDICAL BACKGROUND

1. Current Height: **N/A; Approximately 5'4 before death**

2. Current Weight: **N/A**

3. Approximate weight at the time of your injury: **Unknown. [redacted] lost a significant amount of weight during her illness.**

4.A. To the best of your knowledge, have you, or any blood-relative family member (child, parent, brother, sister, or grandparent), ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please identify who suffered the condition, you or a relative, and please provide the relative's name and relationship to you. If you suffered the condition, please provide the additional information requested in the table following 4(B): **Objection. See attached.**

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO	WHO SUFFERED CONDITION
Abnormal heart rhythm, atrial fibrillation, atrial flutter, ventricular fibrillation, or heart block	X		Brother; self
Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)		X	
Blocked or narrow arteries/plaque buildup/coronary artery disease		X	
Cardiomyopathy/enlarged heart		X	
Chest pain/angina		X	
Congenital heart abnormality		X	[redacted] born w/hole in heart
Congestive heart failure	X		Self; [redacted] may have
Heart attack/MI/myocardial infarction		X	

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO	WHO SUFFERED CONDITION
High blood pressure/hypertension	X		Self
High cholesterol or triglycerides	?		Self
Kidney disease or condition	X		Self
Stroke/transient ischemic attack/TIA/aneurysm	X		Self; brother

4.B. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. If you suffered the condition, please provide the additional information requested in the table following this chart: **Objection. See attached.**

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO
Alcoholism or other substance abuse		X
Alzheimer's, senility, confusion		X
Arthritis (osteoarthritis or rheumatoid arthritis)		X
Autoimmune diseases (e.g., rheumatoid arthritis, lupus, Sjogren's, etc.)		X
Bleeding or clotting disorders		X
Cancer	X	
Chronic obstructive pulmonary disease/COPD/chronic lung disease/asthma		X
Deep vein thrombosis/DVT		X
Depression, anxiety, schizophrenia, bipolar disorder	X	
Dermatologic diseases or conditions		X
Diabetes mellitus		X
Electrolyte imbalance		X
Enlarged prostate, bladder dysfunction		X
Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD, increased or decreased motility)		X
Hardening of the arteries/stenosis/aneurysms		X
Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)	X	
Hormonal replacement therapy	X (Briefly)	
Hypothyroidism/Thyroid condition		X
Immune system disease or dysfunction (including HIV or AIDS)		X
Liver disorder or disease (cirrhosis, hepatitis, etc.)		X
Multiple sclerosis, myasthenia gravis		X
Osteoporosis, bone fractures, calcium deficiency		X
Peripheral vascular disease or peripheral arterial disease		X
Pulmonary embolism/blood clot to the lungs		X
Pulmonary hypertension		X
Raynaud's syndrome/phenomenon		X
Rheumatic Fever/Scarlet Fever	X	
Tobacco use or addiction	X	
Vasculitis		X

For each condition for which you answered Yes in the previous two charts, please provide the information requested below:

[redacted] **provides the following information to the best of her knowlege, with some information gathered from** [redacted] **medical records. Additionally, Plaintiff has executed and attached the medical release. Defendant is free to obtain and review** [redacted] **medical records for futher information.**

CONDITION YOU EXPERIENCED	DATE OF ONSET	MEDICATION/ TREATMENT	TREATING PHYSICIAN AND/OR HOSPITAL
High blood pressure/hypertension	Unknown to [redacted]		Dr. Bruce Fisher
Atrial Fibrilation			
Congestive Heart Failure			
Kidney disease			
Breast cancer	12/2007	Masectomy	Dr. Charles M. Brown Jr
Depression			Dr. Damon Gatewood
Heart murmur			
Hormone Replacement			
Rheumatic Fever	childhood		
Tobacco use	in her 20s	no treatment	

5. Please indicate whether you have ever been the subject of any **cardiovascular surgeries** including, but not limited to, open heart/bypass surgery, CABG, pacemaker or defibrillator implantation, stent placement, vascular surgery, angioplasty, IVC filter placement, carotid (neck) surgery, or valve replacement.

Yes ___ **No** X I don't recall __ If **Yes**, please specify the following:

SURGERY	REASON FOR SURGERY	DATE	TREATING PHYSICIAN	HOSPITAL

6. Please indicate whether you have ever been the subject of any of the following **cardiovascular diagnostic tests** or interventions and provide the requested information about each: including, but not limited to, stress test C-reactive protein (CRP); chest X-ray; angiogram/catheterization; CT scan; MRI; EKG; echocardiogram; TEE (trans-esophageal echo); endoscopy; lung bronchoscopy; carotid duplex/ultrasound; MRI/MRA of the head/neck; angiogram of the head/neck; CT scan of the head; bubble/microbubble study; and Holter monitor.
Objection. Please see attached.

Yes ___ **No** __ I don't recall X If **Yes**, please specify the following:

DIAGNOSTIC TEST/ INTERVENTION	REASON FOR TEST/ INTERVENTION	DATE	TREATING PHYSICIAN/ HOSPITAL	RESULT OF DIAGNOSTIC TEST/ INTERVENTION

7. Do you now or have you ever smoked tobacco products? **Yes** _X_ **No** ___ If **Yes**, please specify the following:

   a. How long have/did you smoke? **Since approximately her twenties**

   b. How much do/did you smoke? **Varied. Plaintiff estimates between one and four packs per week.**

8. Did you drink alcohol (beer, wine, etc.) in the three years before your alleged injury?

   Yes ___ **No** _X_ If **Yes**, please specify the following:

   a. How often did you drink?_____

   b. How much did you drink?_____

9. Have you ever used any illicit drugs of any kind within the five (5) years before, or at any time after, your alleged injury?

   Yes ___ **No** _X_ If **Yes**, identify the substance(s) and your first and last use:_____

   _____

V. ADDITIONAL MEDICATIONS (INCLUDING OTHER DIGOXIN PRODUCTS, SUCH AS LANOXIN®)

1. For any medications, herbal products or supplements other than Digitek® that you took on a regular basis in the ten (10) years prior to, and at the time of, the incidents described in your Complaint, please provide the information requested below:
   Objection. Please see attached.

NAME OF MEDICATION USED	DOSAGE	PRESCRIBING PHYSICIAN	DATES OF USE	PURPOSE OF PRESCRIPTION

NAME OF MEDICATION USED	DOSAGE	PRESCRIBING PHYSICIAN	DATES OF USE	PURPOSE OF PRESCRIPTION

2. Have you ever experienced any side effects while you were taking any of the medications identified in this section in the past ten (10) years?

Yes X **No** ___ If **Yes**, please specify the following:

a. The name of the medication: **Ambien**

b. The side effect(s): **Hallucinations**

c. The date the side effect was experienced: [redacted] **does not recall the exact date but recalls that** [redacted] **was in the hospital at the time.**

VI. PERSONAL INFORMATION

1. Current Address and Date when you began living at this address: [redacted]

2. Social Security Number: [redacted]

3. Date and Place of Birth: [redacted]

4. Marital Status: **widowed**

   If married, spouse's name, occupation and date of marriage: _____

   If divorced, dates of the marriage, case name/jurisdiction for the divorce: _____

   Has your spouse filed a loss of consortium in this action? Yes ___ No **X**

5. If you have children, please list each child's name and date of birth:

   [redacted]

6. For any school attended after High School, please provide the following information:

   a. School Name: **N/A**

   b. Address: _____

   c. Dates attended: _____

   d. Diploma/Degree: _____

7. Employment information for the last ten (10) years. Please include employer's name, address, dates of employment, job title, job description and duties:

   Retired

8. Have you ever served in the military, including the military reserve or National Guard?

   Yes ___ **No** **X**

   If **Yes**, were you ever rejected or discharged from military service for any reason relating to your physical condition? **Yes** ___ **No** ___

If **Yes**, state the condition for which you were rejected or discharged:_____

_____

9. Has any insurance or other company, or Medicare or Medicaid, provided medical coverage to you or paid medical bills on your behalf in the last ten (10) years?

Yes X **No** ___ If **Yes**, please specify the following:

a. The name of the company/agency: **Medicare; United Healthcare**

b. Address: **P.O. Box 740801, Atlanta, Georgia**

c. Dates of Service: [redacted] **believes either Medicare or United paid at least partially for each date of service.**

10. Have you applied for workers' compensation (WC) and/or social security disability (SSI or SSD) benefits in the last ten (10) years?

Yes ___ **No** X If **Yes**, please specify the following:

a. Type of claim:_____

b. Year application filed:_____

c. Agency where application was filed:_____

d. Nature of disability:_____

e. Time period of disability:_____

11. Have you filed a lawsuit or made a claim in the last ten (10) years, other than in the present suit, relating to any bodily injury?

Yes ___ **No** X If **Yes**, please specify the following:

a. Court in which suit/claim filed or made:_____

b. Case/Claim Number:_____

c. Nature of Claim/Injury:_____

12. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?

Yes ___ **No** X If **Yes**, please set forth where, when and the felony and/or crime:_____

_____

VII. HEALTHCARE PROVIDERS AND PHARMACIES

1. Identify each doctor or other healthcare provider who you have seen for medical care and treatment in the past ten (10) years: **Objection. Please see attached.**

NAME AND SPECIALTY	ADDRESS	REASON FOR VISIT	APPROX DATES/YEARS OF VISITS

2. Identify each hospital, clinic, or healthcare facility where you were hospitalized (in-patient, out-patient, or emergency room visit) in the past ten (10) years: **Objection. Please see attached.**

NAME	ADDRESS	ADMISSION DATE(S)	REASON FOR ADMISSION

3. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

NAME OF PHARMACY	ADDRESS	APPROX DATES/YEARS YOU USED PHARMACY
Wal-Mart	**1015 New Moody Lane, Louisville, KY 40031**	

This question is answered based on [redacted] own knowledge and recollection. [redacted] may have also obtained medication through Medco.

VIII. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. If you are filling this out on behalf of an individual who is deceased, please state the following from the Death Certificate of the individual:

(NOTE: In lieu of the following, please attach a copy of the death certificate.)

Date of death: **See attached death certificate.**
Place of death (city, state and county): _____
Facility or location where death occurred: _____
Name of physician who signed death certificate: _____
Cause of death: _____

_____

If you are filling this out on behalf of an individual who is deceased and on whom an autopsy was performed, please fill in the information below pertaining to the autopsy and the autopsy report:

(NOTE: In lieu of the following, please attach a copy of the autopsy report.)

Date: **N/A**
Performed by: _____
Facility where autopsy was performed: _____
Place where autopsy was performed (city, state, county): _____
Describe any and all tissue preserved: _____

IX. FACT WITNESSES

1. Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name address and his/her/their relationship to you:

Name: [redacted]
Address: _____
_____
Relationship to you: [redacted]

Name: [redacted]
Address: [redacted]
_____
Relationship to you: [redacted]

Name: _____
Address: _____
_____
Relationship to you: _____

Name: _____
Address: _____
_____
Relationship to you: _____

Name: _____
Address: _____
_____
Relationship to you: _____

IX. DOCUMENT DEMANDS

1. Authorizations: please sign authorizations that are attached hereto as Exhibit A, for each of the healthcare providers that you have identified above in your Answers to §II, Question Nos. 1-3, and § IV, Question No. 2.

2. Documents in your possession, including writings on paper or in electronic form: If you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet.

   a. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Digitek®.

   b. Copies of the entire packaging, including the box and label, for Digitek® and any Digitek® tablets (plaintiffs or their counsel must maintain the originals of the items requested in this subpart).

   c. All documents relating to your purchase of Digitek®, including, but not limited to, receipts, prescriptions or records of purchase.

   d. All photographs, drawing, journals, slides, videos, DVDs or any other media relating to your alleged injury.

   e. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).

   f. Decedent's death certificate and autopsy report (if applicable).

   g. Medical records, bills, correspondence, reports and all other documents from any health care provider who saw, evaluated or treated Plaintiff/Decedent in the last five (5) years.

   h. All emergency responder, paramedic or EMT reports regarding Plaintiff/Decedent.

   i. Documents concerning any communication between Plaintiff/Decedent or Plaintiff/Decedent's attorneys or agents and the FDA or any Defendant regarding the events giving rise to the lawsuit or relating to Digitek.

   j. Non-privileged documents, including any diaries, calendars or notes that record Plaintiff/Decedent's health, use of Digitek or alleged injuries

X. VERIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge. I have supplied all the documents requested in Part ___ of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and supplied the authorizations attached to this declaration.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respects incomplete or incorrect.

Date: 7-8-09

Signatu[redacted]